TEXAS DEPARTMENT OF INSURANCE
Division of Workers' Compensation - Medical Fee Dispute Resolution (MS-48)
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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name
Doctors Hospital at Renaissance

Respondent Name
Travelers Companies Inc

MFDR Tracking Number
M4-17-0783-01

Carrier's Austin Representative
Box Number 05

MFDR Date Received
November 21, 2016

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "After reviewing the account we have concluded that reimbursement received was inaccurate. Based on CPT Code 99283, allowed amount of $172.83 multiplied at 200%, CPT Code 29515, allowed amount of $104.85 multiplied at 200%, CPT Code 73630, allowed amount of $53.46 multiplied at 200%, and CPT Code 73610, allowed amount of $53.46, multiplied at 200% reimbursement should be $768.20. Payment received was only $554.36, thus, according to these calculations; there is a pending payment in the amount of $213.84."

Amount in Dispute: $213.84

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Carrier has reviewed the billing edits for these procedures, and determined that CPT codes 73610 and 73630 are included with CPT code 99283 for reimbursement. Consequently, separate reimbursement is not due for this procedure."

Response Submitted by: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
June 4, 2016	73610, 73630	$213.84	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and applicable rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.403 sets out the reimbursement guidelines for outpatient hospital

services.

3. The insurance carrier reduced payment for the disputed services with the following claim adjustment codes:
   - 97 – Payment adjusted because the benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated
   - P12 – Workers' compensation jurisdictional fee schedule adjustment
   - B13 – Previously paid payment for this claim/service may have been provided in a previous payment
   - W3 – Additional payment made on appeal/reconsideration
   - 193 – Original payment decision is being maintained. This claim was processed properly the first time.

Issues

1. Are the insurance carrier's reasons for denial or reduction of payment supported?
2. Is the requestor entitled to additional reimbursement?

Findings

1. The requestor is seeking additional payment of $213.84 for outpatient hospital services rendered on June 4, 2016. The carrier denied codes 73610 and 736530 as 97 – "Payment is included in the allowance."

   The outpatient hospital services are subject to the requirements of 28 Texas Administrative Code 134.403 (d) which states in pertinent part,

   > For coding, billing, reporting, and reimbursement of health care covered in this section, Texas workers' compensation system participants shall apply Medicare payment policies in effect on the date a service is provided...

   The applicable Medicare payment policy is found at www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/HospitalOutpatientPPS.

   – **Payment status indicator** - The status indicator identifies whether the service described by the HCPCS code is paid under the OPPS and if so, whether payment is made separately or packaged. The status indicator may also provide additional information about how the code is paid under the OPPS or under another payment system or fee schedule. The relevant status indicator may be found at the following: www.cms.gov, Hospital Outpatient Prospective Payment – Final Rule, OPPS Addenda, Addendum, D1.

Review of the 2016, Addendum B, finds:

- HCPCS Code 73610 has a status indicator of "Q1"
- HCPCS Code 73630 has a status indicator of "Q1"

The Medicare Claims Processing Manual at www.cms.hhs.gov, 10.4 – Packaging,

> *C. Packaging Types Under the OPPSSTV-packaged services are services for which separate payment is made only if there is no service with status indicator S, T, V or reported with the same date of service on the same claim. If a claim includes a service that is assigned status indicator S, T, V reported on the same date of service as the STV- packaged service, the payment for the STV-packaged service is packaged into the payment for the service(s) with status indicator S, T, V and no separate payment is made for the STV-packaged service.* ***STV-packaged services are assigned status indicator Q1****. See the OPPS Webpage at http://www.cms.hhs.gov/HospitalOutpatientPPS/ for identification of STV-packaged codes.*

As the services in dispute have a status indicator of "Q1", they are packaged into the code with the "S" status indicator or 29515. The Carrier's denial is supported no additional payment is recommended.

2. Based on the applicable Rules and Fee Guidelines the Division found no additional payment could be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 additional reimbursement for the services in dispute.

Authorized Signature

		December 15, 2016
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, 37 *Texas Register* 3833, applicable to disputes filed on or after June 1, 2012.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MFDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.